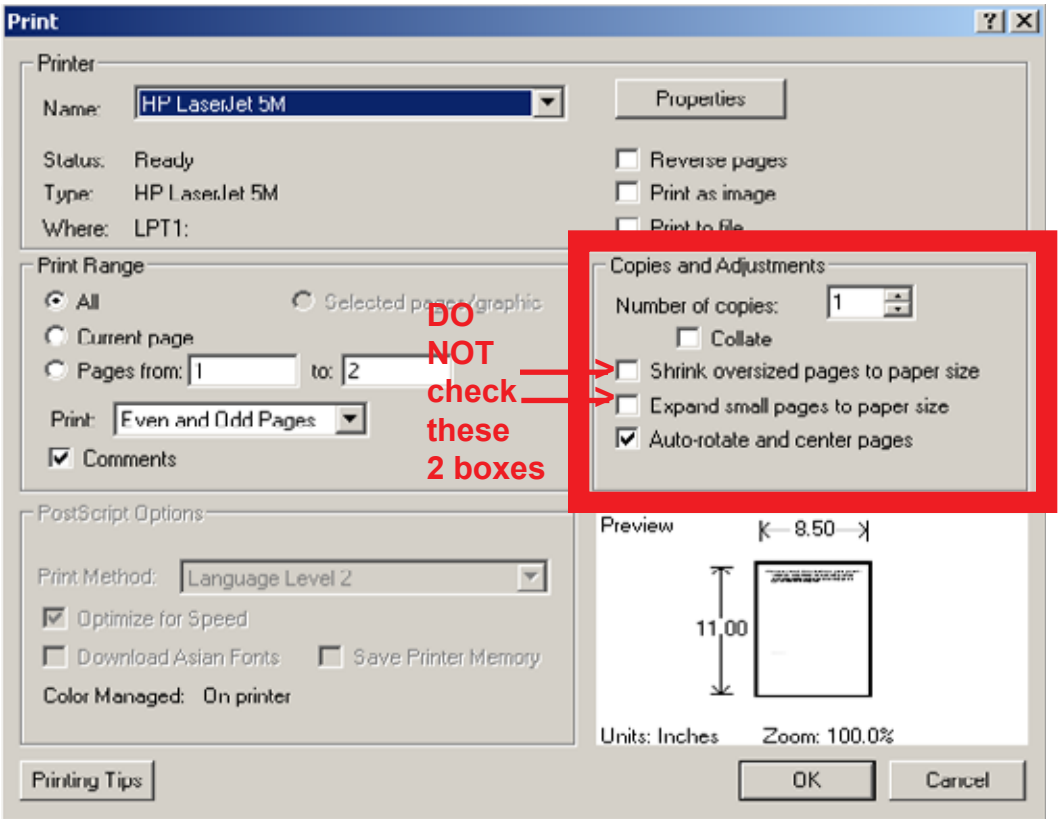
Please read this before you print.

To print applications correctly, it is important to set up your print request as shown below. In the Adobe Acrobat Print dialog box, you must check the box “Auto-rotate and center pages.” Do **not** check the Shrink or Expand boxes.



DOH 600-033 (6/2006)

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Washington State Department of Health
Health Professions Quality Assurance
P.O. Box 1099
Olympia, WA 98507-1099

A. Contents:

Expired Physician Assistant Credential Activation Application Packet (Expired Over Three Years):

B. Important Social Security Number Information:

* Federal and state laws require the Department of Health to collect your Social Security Number before your professional license can be issued. A U.S. Individual Taxpayer Identification Number (ITIN) or a Canadian Social Insurance Number (SIN) cannot be substituted. If you submit an application but do not provide your Social Security Number, you will not be issued a professional license and your application fee is not refundable.

* Federal Personal Responsibility and Work Opportunity Reconciliation Act of 1996, 42 USC 666, RCW 26.23 and WAC 246-12-340.

C. In order to process your request:

1. Complete the Deposit Slip below.
2. Cut Deposit Slip from this form on the dotted line below.
3. Send application with check and Deposit Slip to **PO Box 1099, Olympia, WA 98507-1099**.

Cut along this line and return the form below with your completed application and fees.

Physician Assistant
(Expired Over 3 Years)

DEPOSIT SLIP

NAME (Please Print)

DATE

Revenue Section
P.O. Box 1099
Olympia, Washington 98507-1099

Please note amount enclosed, and return with your application.

$

☐ **Check**
☐ **Money Order**

DOH 656-134 (REV 6/2006)

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STATE OF WASHINGTON
DEPARTMENT OF HEALTH

Application Instructions for Expired Physician Assistant Credential Activation

Expired Over 3 Years

Attached is the abbreviated application packet for re-activation of your expired Washington State credential. When your application is received by the Department of Health, Medical Quality Assurance Commission, you will be sent an acknowledgment letter noting receipt. Program staff will create a pending file and add, as they are received, the incoming supporting documentation needed to complete the process. A deficiency letter will be sent to you approximately every four (4) weeks listing the outstanding documentation still needed to complete the abbreviated application process.

Please Note: WAC 246-918-081 Expired License. Subsection 2 states: "If the license has expired for over three years, the practitioner must: (a) reapply for licensing under current requirements." Current requirements are successful completion of an accredited physician assistant program AND certification by the National Commission on Certification of Physician Assistants (NCCPA).

To ensure that you have submitted the necessary fees, completed the appropriate sections of the application, and requested the required documentation, we encourage you to use the following checklist:

☐ Pay $150.00 in total fees. **(All fees are non-refundable)**

Application for Expired Physician Assistant Credential Activation

☐ ***Section 1: Demographic Information.***

Name: Please list your current name with middle initial.

Residential Address: Please identify the address to which you wish all correspondence, including your credential, delivered. This will become your address of record for all Department of Health transactions until we are notified of a change.

Telephone Number: Enter current number where you may be reached during normal business hours.

Social Security Number: Required for license under 42 USC 66 and Chapter 26.23 RCW.

Additional Data: This information is required to update the Department's Database, and confirm information from your previous (initial) application.

☐ ***Section 2: Previous Credentialing.*** List ***all*** credentials you have held since last being credentialed in Washington State. List in chronological order, most current first. Include your last active credential in Washington State. If you need additional space, attach on a separate piece of paper.

☐ ***Section 3: Professional Experience.*** In chronological order, list all professional work experience since your Washington State credential has expired. Please identify all time breaks of 30 days or more. If you need additional space, attach on a separate piece of paper.

☐ ***Section 4: AIDS Education and Training Attestation.*** Required by WAC 246-12-040 and 246-919-80.

☐ ***Section 5: Criminal and Disciplinary Action Attestation.*** Required by WAC 246-12-040. This section pertains to formal or informal disciplinary action by any regulatory authorities, hospitals, state or federal jurisdictions, criminal convictions, and civil judgments connected with the practice of medicine. If you are unable to attest that you have not had action, please provide a synopsis of

the situation, as well as the appropriate supporting documentation. **The Department does criminal background checks on all applicants.**

☐ ***Section 6: Continuing Education Attestation.*** Required by WAC 246-12-040 and 246-919-430.

☐ ***Section 7: Hospital Privileges.*** Please list in section 8 those hospitals where privileges have been granted in the past five years.

☐ ***Section 8: Applicant's Attestation.*** Required to be signed and dated in order to process the application. Please read thoroughly to ensure your understanding of the provisions in this section.

Additional Documentation Required for Reactivation

☐ ***Professional Liability Action History Form.*** Malpractice information must include the nature of the case, date and summary of care given. The applicant must complete the Professional Liability Action History form for each malpractice case. Applicant must also include copies of the settlement or final disposition. If pending, indicate status. If the case is rather old, you should be able to contact the county where it was filed to get documentation. (Form provided)

☐ ***State Licensure Verification.*** Applicants must verify all medical licenses that he or she holds, or has held, in any other state, territory or possession of the United States or Canadian providence since the expiration date of your previous Washington State credential. Verification is required whether the license is active or inactive. This includes temporary and training licenses. Applicants should contact the state licensing authority for information regarding fees for verification of licensure. (Form provided)

☐ ***Hospital Privileges.*** Applicants must verify all hospitals where admitting or specialty privileges have been granted in the last five (5) years. Verification must be received directly from the hospital. All hospital privileges connected with military practice experiences may be verified by the current duty station or, if no longer in active service, the appropriate agency of record or National Personnel Records Center, (Military Personnel Records), 9700 Page Boulevard, St. Louis, MO 63132. (Form provided)

☐ ***National Commission On Certification of Physician Assistants (NCCPA).*** Applicants must have original documentation sent directly to this office. (Form provided)

☐ ***Federation of State Medical Boards Data Bank Clearance.*** This report will be obtained by Department staff, however, if staff is unable to obtain this report electronically, the applicant will be required to submit the request.

The process of reactivation will involve retrieval of your previous credential file from the state records center. The retrieval time period is approximately two (2) weeks.

Once the abbreviated application is considered complete, it will be referred for review, which will require approximately 14 days for processing a routine application for a final determination and 30 days for non-routine applications. All information, documents, data, etc., provided to the department by the applicant are to be submitted in writing and will become a part of the file. Telephone information will not be accepted in place of written documentation.

Upon approval of reissuance, your license will be activated from the approval date to your ***second*** birthday following that date. The license will be renewable every two years thereafter.

Please note that after approval of your reissuance application, you may **not** practice without a Commission approved practice plan. Practice plan forms may be obtained by calling the numbers listed below.

Applications and fees are to be sent to:

DEPARTMENT OF HEALTH
Medical Quality Assurance Commission
P.O. Box 1099
Olympia, WA 98507-1099

All other inquiries and documents should be directed to:

DEPARTMENT OF HEALTH
Medical Quality Assurance Commission
P.O. Box 47866
Olympia, WA 98504-7866
(360) 236-4785 (A-L)
(360) 236-4784 (M-Z)

Washington State Department of Health
Health Professions Quality Assurance
P.O. Box 1099
Olympia, WA 98507-1099

FOR OFFICE USE ONLY
VALIDATION:
RECEIVED DATE:
ISSUANCE DATE:

Credential #

Application For Expired Physician Assistant Credential Activation (Expired Over 3 Years)

Please Type or Print Clearly—Follow carefully all instructions provided. It is the responsibility of the applicant to submit or request to have submitted all required supporting documents. Failure to do so could result in a delay in processing your application.

All applications must be accompanied by the applicable fee. Make remittance payable to the Department of Health.

1. Demographic Information

APPLICANT'S NAME	LAST	FIRST	MIDDLE INITIAL

RESIDENTIAL ADDRESS

CITY	STATE	ZIP	COUNTY

NOTE: Your credentialing document will show this address and all correspondence from the Department will be sent to this address until you notify us in writing of a change. Pursuant to WAC 246-12-310, it is your responsibility to maintain a current mailing address on file with the Department.

TELEPHONE (ENTER THE NUMBER AT WHICH YOU CAN BE REACHED DURING **NORMAL BUSINESS** HOURS.)	SOCIAL SECURITY NUMBER (**Required** for license under 42 USC 666 and Chapter 26.23 RCW)
( )	— —

GENDER	BIRTHDATE (MONTH/DAY/YEAR)	PLACE OF BIRTH (CITY/STATE)
☐ Female ☐ Male	/ /	

Have you ever been known under any other name(s)? ☐ Yes ☐ No

If yes, list other name(s):

2. Previous Credentialing (Since Last Being Credentialed in Washington State)

STATE/JURISDICTION	PROFESSION	CREDENTIAL			METHOD OF CREDENTIALING	CURRENTLY IN FORCE
		TYPE	YEAR ISSUED	NUMBER		
						☐ NO ☐ YES
						☐ NO ☐ YES
						☐ NO ☐ YES
						☐ NO ☐ YES

3. Professional Experience (Since expiration of your Washington Sate credential _____)

NATURE OF EXPERIENCE OR PRACTICE AND LOCATION	DATES OF EXPERIENCE	
	FROM (MO/YR)	TO (MO/YR)

4. AIDS Education and Training Attestation

I certify I have completed the minimum of four (4) hours of education in the prevention, transmission and treatment of AIDS, which included the topics of etiology and epidemiology, testing and counseling, infection control guidelines, clinical manifestations and treatment, legal and ethical issues to include confidentiality, and psychosocial issues to include special population considerations. I understand I must maintain records documenting said education for two (2) years and be prepared to submit those records to the Department if requested. I understand that should I provide any false information, my license may be denied, or if issued, suspended or revoked.

APPLICANT'S INITIALS

5. Criminal and Disciplinary Action Attestation

I certify that no action has been taken by any state or federal jurisdiction or hospital, which would prevent or restrict my right to practice my profession.

I further certify that I have not voluntarily given up any credential or privilege or have not been restricted in the practice of my profession in lieu of or to avoid formal action.

APPLICANT'S INITIALS

The Department does criminal background checks on all applicants.

6. Continuing Education/Continuing Competency Attestation (If Applicable)

I certify that I have met all continuing education and competency requirements for the past two years. I am enclosing documentation on all courses attended/claimed.

APPLICANT'S INITIALS

7. Hospital Privileges

List hospitals in the U.S. or Canada where hospital privileges have been granted within the past five (5) years. (Attach additional 8 1/2 x 11 sheets if necessary.)

NAME OF HOSPITAL	BEGINNING (MO/YR)	ENDING (MO/YR)

8. Applicant's Attestation

I, _____, certify that I am the person described and identified in this application;
NAME OF APPLICANT

that I have read RCW 18.130.170 and 180 of the Uniform Disciplinary Act; and that I have answered all questions truthfully and completely, and the documentation provided in support of my application is, to the best of my knowledge, accurate. I further understand that the Department of Health may require additional information from me prior to making a determination regarding my application, and may independently validate conviction records with official state or federal databases.

I hereby authorize all hospitals, institutions or organizations, my references, employers (past and present), business and professional associates (past and present), and all governmental agencies and instrumentalities (local, state, federal, or foreign) to release to the Department any information files or records required by the Department in connection with processing this application.

I further affirm that I will keep the Department informed of any criminal charges and/or physical or mental conditions which jeopardize the quality of care rendered by me to the public.

Should I furnish any false or misleading information on this application, I hereby understand that such act shall constitute cause for the denial, suspension, or revocation of my license to practice in the State of Washington.

_____
SIGNATURE OF APPLICANT

_____
DATE

Official Use Only

Washington State Records Center

Washington State Department of Health
Health Professions Quality Assurance
P.O. Box 47866
Olympia, WA 98504-7866
(360) 236-4785 (A-L)
(360) 236-4784 (M-Z)

Washington State Medical Quality Assurance Commission
Applicant's Professional Liability Action History

APPLICANT'S NAME _____ TODAY'S DATE _____

Please submit a ***separate form for each past or current professional liability claim or lawsuit*** which has been filed against you. (Photocopy this page as needed.) Only a legible and signed narrative which addresses all of the following details will be accepted.

1) Provide a detailed summary of the events of the case. Include the date of occurrence, your specific involvement, and the patient's clinical outcome. (Please submit additional pages of narrative if necessary.)

   Date of occurrence: _____ Details: _____

2) Date suit or claim was filed: _____ Name and address of Insurance Carrier that handled the claim: _____

3) Your status in the legal action (primary defendant, co-defendant, other): _____

4) Current status of suit or other action: _____

5) Date of settlement, judgment, or dismissal: _____

6) If the case was settled out-of-court, or with a judgment, settlement amount attributed to you, please disclose amount. (**You must enclose a copy of final disposition of case—this includes dismissals.**) $ _____

I verify the information contained in this form is correct and complete to the best of my knowledge:

SIGNATURE _____ DATE _____

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Washington State Department of Health

PA

TO: State Medical Licensing, Registration, or Certification

STATE BOARD NAME

ADDRESS

RE: Verification of Licensing, Registration or Certification as a Physician Assistant or other health care profession

I am applying for a license to practice as a physician assistant in the State of Washington and before my application can be reviewed, a verification of my license status in your state is required. I am authorizing the release of and would appreciate you providing the information below and returning it, at your earliest convenience, **directly** to the address shown below. **All questions must be answered.**

APPLICANT (PRINT OR TYPE) BIRTHDATE (MONTH/DAY/YEAR)

SIGNATURE OF APPLICANT

This is to verify that _____ was issued license

number _____ on _____ as a _____ .
DATE TYPE OF LICENSE

1. Date license, registration, or certification issued _____ Date of expiration _____ .
2. Have any complaints been lodged against the license? ☐ Yes ☐ No
3. Is there currently any investigation in process regarding the license? ☐ Yes ☐ No
4. Has any disciplinary activity taken place regarding this license? ☐ Yes ☐ No

If yes, please provide any information and documentation which may be released; i.e., charges and final disposition.

Return to:

Department of Health
Medical Quality Assurance Commission
P.O. Box 47866
Olympia, WA 98504-7866
(360) 236-4785 (A-L)
(360) 236-4784 (M-Z)

(Seal)

Signature _____

Print Name _____

Title _____

State _____

Address _____
PLEASE TYPE OR PRINT

Date _____

Telephone _____

(This page intentionally left blank)

Washington State Department of Health

PA

TO: **Hospital Administration**

HOSPITAL NAME

ADDRESS

RE: Verification and Evaluation of Privileges

I am applying for a license to practice as a physician assistant in the State of Washington and before my application can be reviewed, a verification of my employment with evaluations, is required. I am therefore authorizing the release of and would appreciate you providing the appropriate information **directly** to the address shown below at your earliest convenience. **All questions must be answered.**

APPLICANT (PRINT OR TYPE)

BIRTHDATE

SIGNATURE OF APPLICANT

1. _____ now has/has had admitting or specialty privileges at this hospital

   from _____ to _____
   BEGINNING DATE (MONTH & YEAR) ENDING DATE (MONTH & YEAR)

2. **Have those privileges ever been restricted, suspended or revoked by the medical staff or administration?**

   ☐ Yes ☐ No If yes, please explain _____

3. **Has the applicant ever been asked to resign?** ☐ Yes ☐ No If yes, please explain _____

4. We would appreciate any information you feel would assist in the evaluation process. Thank you.

Return to:
Department of Health
Medical Quality Assurance Commission
P.O. Box 47866
Olympia, WA 98504-7866
(360) 236-4785 (A-L)
(360) 236-4784 (M-Z)

(Seal)

Signature _____

Print Name _____

Title _____

State _____

Medical Institution _____
PLEASE TYPE OR PRINT

Address _____

Date _____

Telephone _____